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INTEGRATED CHILD DEVELOPMENT SERVICES SCHEME

DEPARTMENT OF SOCIAL WELFARE
MINISTRY OF EDUCATION AND SOCIAL WELFARE
GOVERNMENT OF INDIA
NEW DELHI

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INTEGRATED CHILD DEVELOPMENT SERVICES SCHEME

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FOREWORD

Children's programmes have been accorded the highest priority in the social welfare sector in the Fifth Five Year Plan. The Government adopted a Resolution on National Policy for Children on August 22, 1974 and set up a National Children's Board, with the Prime Minister as President, on December 3, 1974. The National Policy for the Children recognises the supreme importance of children's programmes in the development of human resources, which are vital to social and economic progress.

The National Policy lays down a 15-point programme for children, child health and nutrition being accorded the highest priority. In pursuance of the National Policy for Children, the Government of India have sanctioned the Integrated Child Development Services scheme which is to be introduced on an experimental basis in the first instance. Thirty experimental projects are to be located in thirty blocks in different parts of the country. Each project will aim at the delivery of a package of services (supplementary nutrition, immunisation, health checkup, referral services, health and nutrition education and non-formal pre-school education) in an integrated manner to pre-school children, expectant and nursing mothers and women in the age-group 15—44 years. The details of the scheme are given in this booklet.

The Programme Evaluation Organisation of the Planning Commission will conduct bench-mark surveys in the project areas and undertake evaluation of these projects after these have been in operation for about a year or two. If the present model is found successful, the Government of India intend extending this project gradually to other blocks in the country. It is, therefore, hoped that the concerned Ministries/Departments of the Government of India, the State Governments, the field officers, autonomous institutions at the national, state and local levels, local bodies and voluntary organisations in the field of child welfare will make sincere and vigorous efforts to make this experiment successful by mutual cooperation and dedication to the cause of national advancement through children's advancement.

(P.N. Luthra)

Secretary to the Govt. of India
Department of Social Welfare

New Delhi.
31 July, 1975.

Beneficiary	Service
5. Children*	i) Supplementary nutrition ii) Immunisation iii) Health check-up iv) Referral services v) Non-formal pre-school education

14. Brief outlines of each of these services are given below. The details, including specific norms where feasible, are worked out in consultation with the respective departments and specialists. It would be necessary to emphasise that this document gives only the model for the scheme. It will be necessary now to make a detailed project formulation exercise for each Integrated Child Development Project. However, implementation of the scheme can commence in the approved project areas, pending finalisation of detailed project plan for each project area.

Supplementary Nutrition

15. Supplementary nutrition will be given to children below 6 years of age and to nursing and expectant mothers from low income families. The amount of nutrition will vary according to the age of the child. The type of food (milk, pre-processed or semi-processed food or food prepared on the spot from locally available foodstuff) will depend upon local availability, type of beneficiary, location of the project, administrative feasibility, etc. First priority will, however, be given to locally available food. Supplementary nutrition will be given for 300 days in a year. The average cost of food per beneficiary is estimated at 25 paise per day. Children who are found, as a result of health check-up, to suffer from second and third degrees of malnutrition will be given supplementary nutrition based on their physical need as recommended by the doctor. The average cost per beneficiary in this case is estimated @ 60 paise per day.

16. The cost of supplementary nutrition has to be met from the provision made for the special nutrition programme in the sector under the Minimum Needs Programme. In exceptionally hard cases, the Central Government may consider providing, in the initial stage only and without

*The age in the upper limit of the group means 5 + but less than 6 years.

future commitment, assistance, for the input of supplementary nutrition.

17. Nutrition and health education will be given to all women in the age-group 15-44 years; priority will be given to nursing and expectant mothers. A special follow-up will be made of mothers whose children suffer from malnutrition or from frequent illness.

18. The methods of carrying the message of health and nutrition-education will be :

i) use of mass media and other forms of publicity ;
ii) special campaigns at suitable intervals aimed at saturating the project area ;
iii) home visits by the anganwadi workers ;
iv) specially organised short courses in the village for about 30 women at a time ;
v) demonstration cooking and feeding ; and
vi) utilization of the health, and nutrition education programme of the Ministry of Health, Agriculture and Irrigation etc. (at the Centre and in the States/Union Territories).

19. The Department of Food in the Union Ministry of Agriculture and Irrigation will extend the facilities of its Mobile Food and Extension Units for training, demonstration and education in the field of nutrition, especially with reference to best use of the locally available nutritious foods. Similarly, effort will be made to secure convergence of the health and nutrition education programme of the Ministry of Health and Family Planning, the Applied Nutrition Programme of the Department of Rural Development in the Ministry of Agriculture and Irrigation and the scheme of functional literacy of women of the Department of Social Welfare in the Ministry of Education and Social Welfare. It is expected that implementation of the scheme of functional literacy of women in the ICDS Project areas will in particular generate general awareness and promote public participation for more effective implementation of this scheme.

Immunisation

20. Immunisation (against small-pox, diphtheria, tetanus, whooping cough, typhoid and tuberculosis) of all children less than 6 years is proposed in the project area. Immunisation against tetanus is proposed

for all the expectant mothers. Immunisation against polio-myeliti' will be given if the local epidemiological situation warrants it. The details regarding immunisation schedule etc. are given in Appendix A.

Health Check-Up and Referral Services

21. This will include.

i) ante-natal care of expectant mothers ;

ii) post-natal care of nursing mothers and care of new born infants.

iii) care of children under six years of age.

22. The details of services proposed to be provided may be seen at Appendix B. In certain areas and in certain cases the scope of health check-up and treatment may be wider. Children requiring referral services at the hospitals in the upgraded PHCs*/district hospitals will be provided appropriate facilities.

Non-formal Education

23. Children 3-5 years will have the benefit of non-formal pre-school education through the institution of anganwadi to be set up in each village and in each centre in an urban project. Where, however, anganwadis, run by voluntary organisations or by Government, are already functioning, these will be utilised for implementing the schemes. The programme in urban projects will be coordinated with that of Aurobindo and Mahavir Centenary Bal Kendras and other similar schemes of the Department of Social Welfare and other Departments in the project area. The anganwadi will be the focal point for delivery of the entire package of child development services.

24. Non-formal pre-school education in these projects will imply the organisation of pre-school activities for children below 6 years of age in each anganwadi. It will not impart formal learning but will develop in the child desirable attitudes, values and behaviour patterns and aim at providing environmental stimulation. No attempt will be made to achieve uniformity of teaching/learning procedure in the anganwadi in regard to all children and in regard to play and other activities. There will be flexibility and the child will be encouraged and stimulated to grow at his own pace. The anganwadi would strive to satisfy the curiosity of the child and channel it in a creative direction. The material to be used in anganwadis should be of indigenous origin, made by the teachers or local artisans, and inexpensive. In determining the content of

*PHC. Primary Health Centre

non-formal/pre-school education, organisation of anganwadis equipment, training, etc., the recommendations of the Education Commission (1964—66), the Report of the Study Group on the Development of the Pre-school Child (1972) etc. are taken into consideration. The anganwadi proposes to establish links with the elementary school so that the child moves from the anganwadi to the school with the necessary emotional and mental preparation.

25. In some villages/centres, anganwadis can be easily started with the readily available trained Balsevikas who are willing to work as anganwadi workers, while in others, anganwadis will be developed by selecting a local woman (preferably), with some educational qualification who will be provided three months' training to enhance her competence to handle the programme.

26. The anganwadi worker will be responsible for :

a) non-formal pre-school education, i.e. organising pre-school activities in an anganwadi for about 40 children in the age-group 3-5 years of age; the toys, play-equipment, etc. to be used should be rural in character and origin, in designing and making which the anganwadi worker will play a leading role;

b) organising supplementary nutrition feeding for children (0—6 years) and expectant and nursing mothers; in planning the menu priority will be given to locally available food and local recipes;

c) giving health and nutrition education to mothers;

d) making home visits for educating parents, particularly in the case of children attending the anganwadi so that the mother of the child can be enabled to play an effective role in the child's growth and development;

e) eliciting community support and participation in running the programme;

f) assisting the Primary Health Centre Staff in the implementation of the health component of Integrated Child Development Service Projects viz. immunisation, health check-up, referral services, and health education;

g) maintaining routine files and records to enable measurement of the impact of the services;

h) reporting to the Child Development Project Officer (to be appointed for each block) the development in the village which require further attention, particularly in regard to the working of the coordinating arrangements of different departments in the village;

i) maintaining liaison with other institutions in the village which have relevance to her functions (mahila mandal etc.); and

j) maintaining liaison with the lady school teacher for assistance in organising pre-school activities and for participation of the primary/middle school girls (where they exist) in the programmes of the anganwadi, thus enabling the girls to acquire work experience.

Selection of Project Areas

27. The administrative unit for the location of Integrated Child Development Services projects will be the community development blocks in rural areas, tribal development blocks in predominantly tribal areas and ward (s) or slums in urban areas.

28. In the selection of projects in rural areas priority consideration will be given to the following factors* :

1) areas predominantly inhabited by tribes, particularly backward tribes;
2) backward areas;
3) drought-prone areas;
4) areas inhabited predominantly by Scheduled Castes;
5) nutritionally deficient areas; and
6) areas poor in development of social services.

29. In the selection of ward (s) in urban areas for urban projects, priority consideration will be given to the following factors :

i) location of slums; and

ii) areas predominantly inhabited by Scheduled Castes.

30. Urban experimental projects will be located in major cities.

31. In the initial stage, however, a major consideration will be the conversion of the existing supplementary nutrition feeding centres, located in tribal and rural areas and in urban slums in the selected ICDS project areas, into anganwadis under ICDS scheme.

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*The serial number does not indicate the order of priorities. Several factors may operate jointly in some areas due to high correlation of their occurance.

32. The selection of project areas will be coordinated with the programme of the Health Ministry to upgrade twentyfive per cent of the Primary Health Centres in Fifth Plan, the programme of the Department of Rural Development in regard to their Applied Nutrition Scheme and the Composite Programme for Women and Children in rural areas, the programmes for protected water supply of the Ministry of Works and Housing and the scheme of Bal Kendras of the Department of Social Welfare. Other programmes of different departments at the Centre and in the States which have a bearing on the successful implementation of the scheme, will also be coordinated with it.

Number of Beneficiaries

33. The demographic and other characteristics vary significantly from block to block. For the purpose of this paper :

A Rural Project (a community development block) is assumed to have a population of 1,00,000 of which 17 per cent i.e. 17,000 are less than 6 years (3 per cent i.e. 3,000 are less than 1 year, 6 per cent i.e. 6,000 are 1-2 years and 8 per cent i.e. 8,000 are 3-5 years); the number of women in the age-group 15—44 years is estimated at 20,000 of this, the number of nursing and expectant mothers is estimated at 7,000.

The number of villages in a rural project is assumed to be 100.

An Urban Project (one or more wards/slums) is assumed to have the same demographic characteristics as a rural project.

A Tribal Project (a tribal development block) is assumed to have a population of 35,000 of which 17 per cent i.e. 5,950 are less than 6 years (3 per cent i.e. 1050 are less than 1 year, 6 per cent i.e. 2,000 are 1-2 years and 8 per cent i.e. 2,800 are 3—5 years); the number of women 15—44 years is estimated at 7,000; of this, the number of nursing and expectant mothers is estimated at 2,450.

The number of villages in a tribal project is assumed to be 50.

34. The above averages have been assumed for the purpose of arriving at a first approximation of the number of beneficiaries, costs etc. However, detailed exercises will be necessary for each project based on actual demographic and other features of each selected project area.

35. The total population in each age group and target population for each project will, on the basis of assumed averages, be as follows (though actual figures will differ for each project as these would depend on the actual demographic and other features of the project area) :—

RURAL PROJECT

(1,00,000 population, 100 villages)

Total population in each group	Service	Target Population	Remarks
Children 0-5 years (17,000 children)	Immunisation	17,000	100 per cent coverage
	Health check-up	17,000	—do—
	Supplementary nutrition	6,800	40% coverage
	Referral	—	
Children 3-5 years (8,000 children)	Non-formal/Pre-school education	4,000	Where necessary 50% coverage
Nursing and expectant mothers (7,000 in number)	Supplementary nutrition	2,800	40%—do—
	Health check-up	2,800	—do—
	Immunisation against tetanus (expectant mothers)	3,500	100% coverage
Women 15-44 years (20,000 women)	Nutrition and health education	20,000	100% coverage progressively

URBAN PROJECT

Same as for rural project

TRIBAL PROJECT
(35,000 population ; 50 villages)

Children 0-5 years (5,950 children)	Immunisation	5,950	100% coverage
	Health check-up	5,950	—do—
	Supplementary nutrition	4,462	75 per cent coverage
	Referral	—	Where necessary
Children 3-5 years (2,800 children)	Pre-school	2,100	75 per cent coverage progressively.
Nursing and expectant mothers (2,450 in number)	Supplementary nutrition	1,835	75% coverage
	Health check-up	1,835	—do—
	Immunisation against tetanus (expectant mothers)	1,225	100% coverage
Women 15-44 years (7,000 women)	Nutrition education	5,250	75% coverage progressively.

Functional Responsibility

36. In the Fifth Five Year Plan the Seheme of Integrated Child Development Services has been classified as a centrally sponsored programme and will be implemented through the State Government with 100 per cent financial assistance from the Central Government. The Central Social Welfare Board, Voluntary organisations, local bodies, panchayati raj institutions (where these are functioning efficiently) etc. are to be actively involved in this programme for implementation, soliciting community support etc. The Central Social Welfare Board and the State Boards should make efforts for organising a larger number of voluntary organisations in the project areas. The intention is to entrust the running of anganwadis to voluntary organizations, local bodies, panchayati raj institutions etc. (wherever these are functioning efficiently) and give them grant-in-aid on the basis of the pattern approved for the anganwadi (Appendix-C). Nutrition inputs can be provided to these bodies by the States. The State Government may itself run an anganwadi only if no organisation as suggested above is available.

37. Since the scheme is based on the strategy of an inter-sectoral approach to the development of children, coordination of the efforts of different ministries and departments at all levels will be necessary.

38. The participation of the Ministry of Health and Family Planning in the scheme of Integrated Child Development Services is as follows :

- i) The Ministry has indicated the norms of the health services to be attained in the project areas (Appendices A & B);
- ii) The PHC and Subordinate Health infrastructure will deliver the following health services to the beneficiaries in the scheme of Integrated Child Development Services :
  - a) health check-up
  - b) referral services
  - c) Immunisation
- iii) For the health services envisaged for children in the project certain personnel (both medical and para-medical) and other inputs will be provided to *Supplement* the primary health service network in the project areas (Appendix-C). In the Fifth Plan, the targets of the Health Ministry in regard to PHCs are (i) one primary health centre for each community development block (ii) one sub-centre for a population of

10,000 (iii) making up the back-log and deficiencies in buildings, staff, equipment etc. (iv) provision of drugs at the enhanced level of Rs. 12,000 per annum per PHC and Rs. 2,000 per annum per sub-centre and (v) upgradation of one in four PHCs to 30 bedded rural hospital. The primary health centre (one in each block) is expected to have 2 Doctors, 3/4 Health Inspectors/Sanitary Inspectors, 2 Lady Health Visitors/Public Health Nurses, 4 Family Planning Health Assistants, 10 A.N.Ms. and 8 basic health workers. The existing health infrastructure including the provision for staff, medicines etc., will have to be upgraded to the approved pattern under the Minimum Needs Programme in the State Sector in each ICDS project area and central assistance under ICDS scheme will be given only for additional staff, medicines etc. required for effective delivery of the health components of the scheme. The *additional* personnel to be provided from the funds of the Integrated Child Development Services project are :

Rural Project :
- 1 doctor, preferably with diploma in child health
- 2 lady health visitors/public health nurses
- 8 A. N. Ms.

Urban Project :
- 1 doctor, preferably with diploma in child health
- 4 A. N. Ms.

Tribal Project :
- 1 doctor, preferably with diploma in child health
- 2 lady health visitors/public health nurses
- 4 A. N. Ms.

iv Additional inputs of personnel, equipment, etc. from the Integrated Child Development Services budget will form an integral part of the overall PHC structure and not function as a separate entity. The PHC would, however, assume responsibility to meet the targets envisaged for the project.

v) The upgradation of PHCs in the Fifth Plan should converge with the opening of Integrated Child Development Services projects. This will have the merit of not only ensuring better referral services to the beneficiaries of the Integrated Child Development Service project but will also have the advantage of having a fully set up PHC since priority is proposed to be given in the Fifth Plan towards ensuring that the entire complement of staff, medicines, etc. is available in the upgraded PHCs so that they do not suffer from shortages of personnel, equipment, medicines etc.

vi) Since the PHC structure would function under the administrative control of the Department of Health in the States, the Department of Social Welfare in the States would not excercise administrative control over the staff provided under the Integrated Child Development Services budget. The State Social Welfare Departments would deal with the State Health Departments who would be administratively responsible for attaining the Integrated Child Development Services targets.

vii) The Health Departments in the States/Union Territories would make available their services for health and nutrition education of women 15-44 years in the Integrated Child Development Projects.

viii) Production of vaccines, medicines etc. to cover the target groups for the Integrated Child Development Services would be met by the Union Ministry of Health and Family Planning from its own allocations.

ix) In urban areas, the urban family welfare planning of the Department of Family Planning will be linked with the urban project of Integrated Child Development Services.

x) The training of A.N. Ms. and other personnel for the delivery of health services envisaged in the Integrated Child Development Services Projects, will be arranged by the Ministry of Health and Family Planning.

Flow of administrative control

39. A diagrammatic representation of flow of administrative control in the implementation of Integrated Child Development Services Project in rural/tribal blocks is given at Appendix D. A Coordination machinery

will be set up at all levels as the scheme is basically an inter-departmental endeavour.

40. The Department of Social Welfare will be responsible for budgetary control and administration of the Scheme from the Centre. At the State level, the Secretary of the Department of Social Welfare will be responsible for the implementation of the project. At the district level, the district social welfare officer will be responsible for coordination of the implementation of the scheme; in districts where he is not in position, the function may be discharged by the district development officer/district planning officer.

41. A Child Development Project Officer will be appointed for implementation of the programme at each block. He will be directly incharge of the scheme; however, the B.D.O. will exercise, over-all responsibility, as for schemes of other Departments in the Block. The CPDO will be responsible for implementing the scheme at the field level. The CPDO should be carefully selected and should preferably be a graduate in Child Development, Social Work, Home Science, Nutrition or any allied field.

42. As stated earlier, the anganwadi will be the focal point for the delivery of services. Immunisation, health check-up and referral services will be delivered at the anganwadi through the network of health services in the project area. The services of supplementary nutrition feeding, nutrition and health education and non-formal pre-school education will be provided through the agandwadi with support from the community development, health and other departments.

43. In the case of urban projects, the Child Development Project Officer will be responsible to the State Social Welfare Department for the implementation of the scheme.

Personnel

44. As stated earlier, the Child Development Project Officer will be incharge of the project. Each village will have an anganwadi worker. She will be assisted by a helper in organising supplementary nutrition feeding programme etc. The number of anganwadi workers in each project area will be as follows (on the basis of assumed averages though actual figures will vary from project to project) :

Rural Project : **(100 villages)**	100 anganwadi workers
Urban Project ; **(100 centres)**	100 anganwadi workers
Tribal Project : **(50 villages)**	50 anganwadi workers

45. The anganwadi worker may be a matriculate or not. If she is a matriculate, she will receive an honorarium of Rs. 150/- p.m. and if she is a non-matriculate she will receive an honorarium of Rs. 100/- p.m. Each urban project will have all matriculate anganwadi workers, though the proportion of matriculate and non-matriculate anganwadi workers will vary from project to project in rural/tribal areas.

46. As one CDPO will not be able to supervise and guide the work, of 50 to 100 aganwadi workers, five, four and three supervisors of the rank of mukhya sevikas will be provided in each rural, urban and tribal project respectively.

47. The health personnel to be provided from ICDS budget are indicated above in paragraph 38 (iii).

48. Even though funds will be provided by the Central Government, the staff will be borne on the appropriate cadres of the States and, therefore, the State should sanction the posts (as per Appendix C) in the appropriate corresponding State pay scales. The anganwadi workers will be honorary workers.

Project Formulation, Monitoring and Evaluation

49. A technical cell is being set up for monitoring and evaluation. This will be a constituent of the Planning, Research, Evaluation and Monitoring Division in the Department of Social Welfare. This cell will also devise an appropriate communication or information net work in the project area, and will give special attention to communication aspects of nutrition education. A nucleus secretarial set-up in the Department of Social Welfare will direct the entire programme.

Cost Estimates

50. The detailed cost estimate for each project for a *year* is given in Appendix—C, excluding the nutrition component which is to be provide from the State sector under the Minimum Needs Programme. The cost estimate is an approximation and the actual expenditure will differ from project to project because the pay scales etc. are different from State to State.

51. The cost in regard to (i) health component i.e; strengthening of PHC structure as per Appendix C, (ii) anganwadis, (iii) supervisors and (iv) child development project officer will be fully borne on the

Integrated Child Development Services Project budget in the centrally sponsored sector. The cost in regard to supplementary nutrition feeding will be borne in the nutrition sector in the State Plan.

Training of personnel

52. The functionaries of Integrated Child Development Services projects will have to be trained or appropriately oriented for the tasks expected of them. The training/orientation of different personnel will be arranged by the Department of Social Welfare, Government of India and the entire expenditure thereon will be borne by the Government of India. For this purpose, detailed guidelines will be issued from time to time. Action in regard to some training orientation courses has already been initiated and necessary communications have been sent to the States and the concerned Institutions (letter No. 6-11/75- NCD dated July 21, 1975 from the Department of Social Welfare, Government of India to the State Governments and others concerned). The National Institute of Public Cooperation and Child Development, New Delhi, F.C.W.* Training Centres, Jamia Milia (New Delhi) and Baroda and some gramsevika training centres/balsevika training institutes of the Indian Council for Child Welfare/training centres of the Bharatiya Adimjati Sevak Sangh are actively involved in the training programmes. The syllabi for the training of some functionaries, for whom the courses are being organised have been issued separately.

Forms

53. Some forms and registers have to be maintained at diffierent levels. These will be simple and few. The States may use regional languages for these forms and registers, if they so desire, but reports to the Government of India may be sent in Hindi or English only. The specimen forms and registers will be sent to the States alongwith the syllabi for the training of various categories of functionaries (vide para 52 above).

The Role of UNICEF, WFP and CARE

54. The UNICEF have evinced keen interest and participated in the programme of child development in India. They are eager to participate in the successful implementation of the present programme as well which envisages, on an experimental basis, the implementation of a coordinated

* F.C.W. Family and Child Welfare

strategy for the development of the child. Some of the areas of UNICEF participation are consultancy service, training, supplies, equipment monitoring, research and evaluation. WFP and CARE have evinced interest in this scheme. Their food commodities for the Special Nutrition Programme can be used, wherever considered desirable, for meeting the nutrition component of this scheme (this applies to States which receive WFP and CARE food commodities for Special Nutrition Programme).

Appendix A

IMMUNIZATION*

Immunization against smallpox, tuberculosis, diphtheria, whooping cough, tetanus and typhoid for all children under six years of age and immunization against tetanus of all the expectant mothers in the project area is proposed. The local PHC structure will be responsible for implementing this. The following schedule of immunization is recommended to be used in the project:—

Immunization schedule:

Age	Vaccination
1. At birth or as soon after as possible	B.C.G. and Smallpox vaccination.
2. 4 months to 9 months	Primary immunization with D.P.T. (triple vaccine)—2 doses at an interval of 8—12 weeks.
3. 12—18 months	Small-pox revaccination. First booster dose of D.P.T. T.A.B. Vaccination 2 doses at 7-10 days interval.
4. 5—6 years	Smallpox revaccination. BCG revaccination. Second Booster dose with D.T. Vaccine, T.A.B. 2 doses at 7—10 days interval.

If immunization against Poliomyelitis is required to be given, three doses of trivalent oral vaccine should be used at 4—6 weeks interval starting the first dose at 4 months of age.

Immunization against cholera should be given if the local epidemiological situation requires it.

*As revised by Ministry of Health and Family Planing.

The schedule suggested above would be applicable to infants under one year of age when the project is started and to the children who would be born after the project is initiated. However, the majority of children between 1 to 6 years of age in the project areas would not have received the immunization. Therefore, during the first year of the project intensive efforts should be made to immunise children in this age group. Those who have not received primary vaccination against smallpox as detected by the absence of scars will be given the Smallpox vaccination. Similarly, children without the B.C.G. scars should be given the B.C.G. Vaccination. Children between one to three years of age who have not received triple vaccine should be given the same with two doses at an interval of 8 to 12 weeks. Children between 3 to 6 years of age should be given two of D. T. (Diphtheria-tetanus) at an interval of 8 to 12 weeks; doses of T.A.B. vaccine of 7—10 days interval between the doses should be given to all children Once the backlog of unprotected older children is covered (in subsequent years of the project) attention should be paid to the immunization of new-born infants according to the recommended schedule.

Tetanus Immunization for Expectant Mothers

Schedule of Immunization

24-26 weeks	...	1st dose
34-36 weeks	...	2nd dose

Care should be taken to see that the interval between the two doses is not less than 8 weeks which may be extended to 12 weeks if necessary. The second dose should be given atleast 4 weeks before the expected date of delivery. Mothers registered at Ante-Natal Clinics after 36 weeks of pregnancy need not be started on Tetanus Immunization as there would not be sufficient time for completing the course before delivery.

The mothers who have received the primary course of immunization during one pregnancy should be given a booster dose with one injection of the Toxoid during subsequent pregnancies, about 4 weeks before the expected date of delivery.

The dates of immunization of children should be recorded in the Child Health Card and those for expectant mothers in the Ante-Natal Cards which should be kept in respect of the individal child and the mother. In addition, a register of immunizations should also be maintained. The entries will be made by the Doctor/Lady Health Visitor incharge of the Centre who administered the injections.

Appendix-B

Health Check up and Referral Services

These services will include:—

(i) Ante-Natal care of expectant mothers

(ii) Post-Natal care of nursing mothers and care of new borns

(iii) Care of children under six years of age.

(i) Ante-Natal Care of Expectant Mothers :

At the Ante-Natal Clinics, apart from complete physical and obstetrical examination of the mother, serial recording of weight, blood pressure haemoglobin and examinations of urine should be done as a routine. Immunization against tetanus should be given. Iron and Folic Acid tablets alongwith protein supplements should be given. Attention should be paid to health education of the mother on hygiene of pregnancy/breast feeding of the infant and other aspects of mother craft and child rearing with special reference to the spacing of the next child.

A minimum of four physical examinations of the mother during her pregnancy should be the target. Of these, atleast one visit should be in the home of mother and one visit after 36 weeks of pregnancy.

High risk mothers identified during the ante-natal clinics, i.e. mother with bad obstetrical history, grand multi-para, mothers with medical problems like tuberculosis, diabetes etc; should be referred to appropriate institutions for special care.

Records of ante-natal care should be kept in Ante-Natal Card.

(ii) Post-Natal Care :

As most of the mothers in rural areas deliver in their homes, only limited post-natal care will be possible to be given to them. Efforts should be made to give post-natal visits to mothers in their homes twice within the 10 days after delivery in those villages where primary health centres and sub-centres are located, and villages nearby. In other areas atleast one visit within the first month after delivery should be aimed at. However, in the urban projects more frequent and better post-natal care could be organised. These visits should be utilised to check on the general health and well-being of the mother, establishment of successful breast feeding of the new born and attention to the general health of the infants. Records of the deliveries attended by PHC personnel should be kept in the relevant card.

Greater emphasis should be placed on inducing the mother to come to the clinic for post-natal examination of herself as well as of her infant 6 to 8 weeks after her delivery. The post-natal clinic will provide general physical examination of the mother with special reference to the condition of her breast, abdomen, perineum and pelvic organs to ensure that she has regained her general health and is fit to resume her normal work as well as to examine the child and advise on its health and nutrition requirements. At the post-natal clinics, mothers will be helped to adopt a suitable method for spacing the next birth or for limiting the family size as the case may be. The findings of the post-natal examination and the acceptance of the family planning method should be entered in the ante-natal delivery card of the mother.

(iii) Care of children under six years of age :

The following activities are proposed :

1. Serial recording of the height and weight of children with a view to keeping close watch over their nutrition status.
2. Watch over other mile-stones in the growth and development of the child.
3. Provide all the immunisations according to the policy enunciated.
4. Provide general check-up every three/six months in order to detect diseases and other evidences of malnutrition or infection.
5. Provide treatment for the widely prevalent diseases like diarrhoea, dysentry, upper respiratory-tract infections, skin diseases, eye diseases like trachoma, conjunctivitis etc.
6. Deworming against the prevalent parasitic infections, round-worm, thread-worm, hookworm etc.
7. Prophylactic measures against diseases of nutritional origin like anaemia, vitamin deficiencies, marasmus etc. through distribution of drugs and diet supplements.
8. Refer serious cases to the appropriate hospital for specialised treatment.

Health records of children should be maintained in cards. A card should also be given to the mothers of children under five years of age, with a view to educating and sustaining their interest in the health of their small children and make them avail of the services offered by the project.

Referral Services

Pregnant mothers and children, with problems requiring specialised treatment will be referred to the upgraded PHC/Sub-division/Dirtrict Headquarters Hospital as the case may be. The Medical Officer of PHC will refer such cases with a referral slip prescribed for the purpose. The hospital after completing the treatment will refer the mother/child back to the Primary Health Centre with notes of the treatment given and further treatment/advice to be followed.

Records and Registers :

1. Register of D.P.T./Tetanus immunization
2. Ante natal card
3. Delivery card
4. Child's card over 5 years
5. Child's card under five years of age
6. Referral card
7. Nominal Register

Item
A. STAFF
1. Child Developme Project Officer
2. Assistant
3. Supervisors

Referral Services

Pregnant mothers and children, with problems requiring specialised treatment will be referred to the upgraded PHC/Sub-division/Dirtrict Headquarters Hospital as the case may be. The Medical Officer of PHC will refer such cases with a referral slip prescribed for the purpose. The hospital after completing the treatment will refer the mother/child back to the Primary Health Centre with notes of the treatment given and further treatment/advice to be followed.

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6. Referral card
7. Nominal Register

Appendix - C

Cost Estimate of ICDS Project (One year)

Item	Rural Project	Urban Project	Tribal Project	Remarks
A. STAFF				
1. Child Development Project Officer	10,000	10,000	10,000	One CDPO in each project in the same payscale as that of BDO.
2. Assistant	3,000	3,000	3,000	One Assistant in each project in the scale of the lower division clerk.
3. Supervisors	24,000	19,200	14,400	Five, four and three supervisors in each rural, urban and tribal project respectively, in the pay scale as that of Mukhyasevikas in the States.
4. Clerk/Typist	3,000	3,000	3,000	
5. Anganwadi Workers *(Honorarium @ Rs. 125-175p.m.)	1,56,5000	1,86,500	75,500	Honorarium @ Rs. 175 p.m. for matriculates and Rs. 125 p.m. for non-matriculates. 100 workers in each rural project (say 50% non-matriculate) 100 workers in each urban project (all matriculate) 50 workers in each tribal project (say 50% matriculate and 50% non-matriculate)
6. Driver	3,000	3,000	3,000	One driver in each project.
7. Helpers ** @ Rs. 50/- p.m.	60,000	60,000	30,000	100 in each rural/ urban project and 50 in each tribal project.
8. Peon	2,500	2,500	2,500	
Total	2,62,000	2,87,200	1,41,400	

* Earlier the honorarium was Rs. 150 and Rs. 100 p.m. respectively,

** Earlier the honorarium was Rs. 35/- p.m.

.. 2/-

1.	2.	3.	4.	5.
Strengthening of staff in PHC/Sub-centres				
1. Doctor (pereferably with diploma in child health.	12,000	12,000	12,000	One Doctor in each project
2. Lady Health Visitor/ Public Health Nurse	10,000	-	10,000	Two LHV/PHN in each rural /tribal project.
3. A.N.M.	28,800	14,400	14,400	Eight, four and four ANM in each rural, urban and tribal project, respectively
	50,800	26,400	36,400	
Total staff	3,12,800	3,13,600	1,77,800	
B. OTHER EXPENSES				
Recurring				
1. Contingencies for Anganwadis	15,000	15,000	7,500	100 Anganwadis in each rural/urban project and 50 anganwadis in each tribal project
2. Rent for anganwadis (@Rs. 100 p.m. for urban project only)	-	1,20,000		Premises in rural/ tribal areas to be provided by the community.
3. Medicines	22,500	22,500	8,500	
4. POL, maintenance, etc	25,000	12,500	25,000	
5. Contingencies at block level (stationery etc.)	4,000	4,000	4,000	
6. Rent of buildings for medical and paramedical staff.	5,000	*	3,600	
	71,500	1,74,000	48,600	

.. 3/-

Referral Services

Pregnant mothers and children, with problems requiring specialised treatment will be referred to the upgraded PHC/Sub-division/Dirtrict Headquarters Hospital as the case may be. The Medical Officer of PHC will refer such cases with a referral slip prescribed for the purpose. The hospital after completing the treatment will refer the mother/child back to the Primary Health Centre with notes of the treatment given and further treatment/advice to be followed.

Records and Registers :

1. Register of D.P.T./Tetanus immunization
2. Ante natal card
3. Delivery card
4. Child's card over 5 years
5. Child's card under five years of age
6. Referral card
7. Nominal Register

1.	2.	3.	4.	5.
Non-recurring				
1. Equipment for Anganwadis	75,000	75,000	37,500	100 anganwadis in each rural/urban project and 50 anganwadis in each tribal project.
2. Furniture, etc. at block/PHC level	5,000	4,000	5,000	
3. Refrigerator	5,000	5,000	5,000	*One in each project
4. Van	50,000	50,000	50,000	
	1,35,000	1,34,000	95,500	
Total project expenditure Recurring	3,84,300	4,87,600	2,26,400	
Non-recurring	80,000	79,000	40,500	
Total	4,64,300	5,66,600	2,66,900	

* These articles are being supplied by UNICEF and hence provision not suggested.

/SAINI/

1.	2.	3.
<u>Non-recurring</u>		
1. Equipment for Anganwadis	75,000	75,000
2. Furniture, etc. at block/PHC level	5,000	4,000
3. Refrigerator	5,000	5,000
4. Van	50,000	50,000
	1,35,000	1,34,000
Total project expenditure Recurring	3,84,300	4,87,600
Non-recurring	80,000	79,000
Total	4,64,300	5,66,600

* These articles are being supplied by UNICEF and suggested.

Appendix—C

Cost Estimate of ICDS Project (one year)

Item	*Rural Project*	*Urban Project*	*Tribal Project*	*Remarks*
(1)	(2)	(3)	(4)	(5)
A. Staff				
1. Child Development Project Officer	10,000	10,000	10,000	One CDPO in each project in the same pay-scale as that of BDO.
2. Assistant	3,000	3,000	3,000	One Assistant in each project in the scale of the lower division clerk.
3. Supervisors	24,000	19,200	14,400	Five, four and three supervisors in each rural, urban and tribal projects respectively, in the pay scale as that of Mukhyasevikas in the States.
4. Anganwadi workers (honorarium © Rs. 100-150 p.m.)	1,50,000	1,80,000	75,000	Honorarium @ Rs. 150 p.m. for matriculates and Rs. 100 p.m. for non-matriculates. 100 workers in each rural project (say 50% matriculate and 50% non-matriculates. 100 workers in each urban project (all matriculates) 50 workers in each tribal project (say 50% matriculates and 50% non-matriculates)
5. Driver	3,000	3,000	3,000	One Driver in each project.
6. Helper @ Rs. 35 p.m.	42,000	42,000	21,000	100 in each rural/urban project and 50 in each tribal project.
	2,32,000	2,57,200	1,26,400	

(1)	(2)	(3)	(4)	(5)
Strengthening of Staff in PHCs/Sub-Centres				
1. Doctor (preferably with diploma in child health)	12,000	12,000	12,000	One doctor in each project.
2. Lady Health Visitor/ Public Health Nurse	10,000	—	10,000	Two LHV/PHN in each rural/tribal project.
3. A.N.M.	28,800	14,400	14,400	Eight, four and four A.N.Ms in each rural, urban and tribal project, respectively.
	50,800	26,400	36,400	
Total staff	2,82,800	2,83,600	1,62,800	
B. Other Expenses				
Recurring				
1. Contingencies for Anganwadis	15,000	15,000	7,500	100 Anganwadis in each rural/urban project and 50 Anganwadis in each tribal project (list attached).
2. Rent for anganwadis (@ Rs. 100 p.m. for urban project only)	—	1,20,000	—	Premises in rural/tribal areas to be provided by the community.
3. Medicines	18,000	18,000	6,500	(As worked out and suggested by Ministry of Health & Family Planning during discussions with the Planning Commission.

(1)	(2)	(3)	(4)	(5)
4. POL. maintenance etc.	20,000	10,000	20,000	
5. Contingencies at block level (stationery etc.)	4,000	4,000	4,000	
6. Rent of buildings for medical and paramedical staff	5,000	*	3,600	*HRA at admissible rates but not computed into monetary terms. Rent calculated at 10% of salary.
	62,000	1,67,000	41,600	
Non-recurring				
1. Equipment for Anganwadis	75,000	75,000	37,500	130 anganwadis in each rural/-urban project and 50 anganwadis in each tribal project.
2. Furniture, etc. at block/PHC level	5,000	4,000	3,000	
3. Refrigerator	5,000	5,000	5,000	One in each project.
4. Van	50,000	50,000	50,000	One in each project.
	1,35,000	1,34,000	95,500	
Total project exp. Recurring	3,44,800	4,50,600	2,04,400	
Non-recurring	1,35,000	1,34,000	95,500	
Total	4,79,800	5,84,600	2,99,900	

3. Soap containers—1 or 2		4.00
4. Towels (4)		20.00
5. Disinfectant Fluid	To be met from recurring or miscellaneous	
6. Brooms, Brushes and other cleaning material		

IV. Indoor Play Equipment

1. Building blocks (wooden of different sizes)		30.00
2. Counting frames		100.00
3. Paints and brushes and coloured chalk sticks		80.00
4. Dholak 1		20.00
5. Scissors 3-4		40.00
		731.00
	Say Rs.	750.00

Note—Those items which can be made by the Anganwadi workers should not be bought from the market.

DISTRICT	The District Social Welfare Officer will be incharge. Where he is not in position, the District Development Officer/ Planning Officer will be incharge.	A Coordination Committee with Collector as chairman, Chairman of the district branch of C.S.W.B. as Vice-Chairman, District Social Welfare Officer as Convener, and district level officers of the Departments concerned, representatives of I.C.C.W. C.S.W.B. and other voluntary organisations as members.
BLOCK	The Child Development Project Officer will be directly incharge. The B.D.O. will exercise overall responsibility as for schemes of other Departments in the Block. Supervisors (i.e. Mukhyasevikas)	A Co-ordination Committee with the Chairman of the Block mahila mandal as Chairman, the Child Development Project Officer as Convener, and the PHC doctor incharge, block level officers of departments concerned with the programme and representatives of voluntary organisations, as members. In States where the panchayati raj institutions are well organised the Pradhan or his nominee may also be a member.
VILLAGE	Anganwadi worker will be incharge of implementation of the programme.	A Co-ordination Committee with the Sarpanch or a prominent woman social worker as the Chairman, Anganwadi worker as the Convener and school teachers, officials of other departments concerned, woman social workers as members.

Annexure I

List of ICDS Project Areas/Blocks.

Sl. No.	Name of the State	Nature of project area	Name of the Block selected	District
(1)	(2)	(3)	(4)	(5)
1.	Andhra Pradesh	Rural-1	Kambadur	Anantapur
		Tribal-1	Utnoor	Adilabad
2.	Assam	Rural-1	Dhakuakhana	Lakhimpur
3.	Bihar	Rural-2	Manigachi	Darbhanga
			Tarapur	Monghyr
		Tribal-1	Barajamda	Singhbhum
4.	Gujarat	Tribal-1	Chhotaudepur (Tejghar PHC area)	Baroda
5.	Haryana	Rural-1	Kathura	Sonepat
6.	Himachal Pradesh	Tribal-1	Pooh	Kinnaur
7.	Jammu & Kashmir	Rural-1	Kangan	Srinagar
8.	Karnataka	Rural-1	T. Narasipur	Mysore
9.	Kerala	Rural-1	Vengara	Tirur Taluk (Malappuram)
10.	Madhya Pradesh	Rural-1	Singroli	Sidhi
		Tribal-1	Tokapal	Bastar

(1)	(2)	(3)	(4)	(5)
11.	Maharashtra	Tribal-1	Dharni	Amravati
		Urban-1	Bombay (a group of slums)	
12.	Manipur	Rural-1	Umkhrul	East District
13.	Meghalaya	Tribal-1	Songsak	Garo Hills
14.	Nagaland	Tribal-1	Zeliangkuki	Kohima
15.	Orissa	Tribal-1	Subdega	Sundargarh
16.	Punjab	Rural-1	Nurpur Bedi	Rupar
17.	Rajasthan	Tribal-1	Garhi	Banswara
18.	Tamil Nadu	Urban-1	Madras (a group of slums to be selected by State Government)	
		Rural-2	Thalli	Dharmapuri
			Nilakottai	Madurai
19.	Tripura	Rural-1	Chawmanu	North Distt.
20.	Uttar Pradesh	Rural-3	Shankargarh	Allahabad
			Lalganj	Rae Bareilly
			Jawan	Aligarh
21.	West Bengal	Rural-1	Man Bazar	Purulia
		Urban-1	Ward No. 79 and 85 Kidderpore Area	Calcutta
22.	Sikkim	Rural-1	Gyalzing and Namchi districts	
23.	Delhi	Urban-1	A group of slums in Jama Masjid, Matia Mahal, Turkman Gate, Ajmeri Gate Areas.	Delhi

Annexure II

List of Training Institutions for Training of Anganwadi Workers

Sl. No.	*State*	*Training Centre selected for training Anganwadi Workers*
(1)	(2)	(3)
1.	Andhra Pradesh	GTC, Rajendranagar GTC, Samalkot
2.	Assam	GTC, Jorhat,
3.	Bihar	BASS Training Centre, Deoghar
4.	Gujarat	Tribal Women's Trainning Centre (BASS), Jhalod, Gujarat
5.	Haryana	BTI, Chandigarh
6.	Himachal Pradesh	GTC, Mashobra
7.	Jammu & Kashmir	BTI Jammu Jagiriti Niketan
8.	Karnataka	GTC, Mandya
9.	Kerala	GTC, Taliparamb
10.	Madhya Pradesh	GTC, Obaidullaganj GTC, Powerkheda

(1)	(2)	(3)
11.	Maharashtra	GTC, Manjri (Poona) BTI, Kosbad (Bombay)
12.	Manipur	BASS Taining Centre, Imphal
13.	Meghalaya	GTC, Shillong
14.	Nagaland	BASS Training Centre, Women's Hostel Building, Dimapur
15.	Orissa	GTC, Bhubaneshwar
16.	Punjab	GTC, Batala
17.	Rajasthan	GTC, Jodhpur
18.	Tamil Nadu	Service Home, Tambaram, Madras BTI, Madras,
19.	Tripura	GTC, Fulia Colony Nadia, West Bengal
20.	Uttar Pradesh	AETC, Afimkothi, Pratapgarh AETC, Bichpuri, Agra AETC, Faizabad.
21.	West Bengal	GTC, Sriniketan (Rural) BTI, Calcutta (Urban)
22.	Sikkim	Teachers' Training Centre, Pellin, near Gyalzing
23.	Delhi	BTI, Delhi

Abbreviations : GTC—Gramsevika Training Centre
BASS—Bhartiya Adimjati Sevak Sangh
BTI—Balsevika Training Institute
AETC—Agriculture Extension Trg. Centre

Annexure III

List of State Level Officers in Charge of ICDS Projects

Sl. No.	*Name of State*		*Name & designation of the officers in charge of the ICDS in the State*	*Telephone Number*
1.	Andhra Pradesh	(i)	Shri Dilsukh Ram, Secretry.	
		(ii)	Shri B. Nageswara Rao, Deputy Secretary to Govt. and Director of Nutrition Programme, Employment & Social Department Hyderabad.	32784
		(iii)	Dr. Smt. A. Vanjakshi, M.A., M.Ed., Ph.D., Director, Women and Child Welfare Department, Hyderabad.	
2.	Assam	(i)	Shri A.K. Chowdhary I.A.S., Secretary, Tribal Areas & WBC Deptt. Dispur, Gauhati.	
		(ii)	Shri N.N. Narzari I.A.S. Director of Social Welfare Assam, Gauhati.	(Gauhati) 7221
		(iii)	Shri S.C. Bhattacharjee, Under Secretary to the Government of Assam, Tribal Areas and Backward Classes Welfare Department, Dispur.	
3.	Bihar	(i)	Shri Gejendra Narain Dy Secretary, Social Welfare & Forest Department, Government of Bihar, Patna.	
		(ii)	Shri M.L. Mazumdar, Director, Social Welfare and Forest Department, Patna.	
4.	Gujarat	(i)	Shri Y.M. Oza, Deputy Secretary, Panchayat & Health Department, Gandhinagar.	Office : 2211 PABX : 361 Res : 2586
		(ii)	Shri S.J. Shah, Dev. Commissioner, Block No. 11, Sachivalaya, Gandhinagar.	Office : 2811 Res : 85484 (Ahmedabad)

(2)		(3)	(4)
5. Haryana		Mrs. K. Dewan, Joint Director. Social Welfare, Haryana, Chandigarh.	88986
6. Himachal Pradesh	(i)	Shri R.C. Gupta, Secretary, Social Himachal Pradesh, Simla.	3307
	(ii)	Shri P.S. Negi, Director of Social Welfare, Raksha Neelam Bldg. Simla.	2001
	(iii)	Shri S.K. Gupta, Child Development Project Officer, C/O Director, Social Welfare, Raksha Neelam Bldg., Simla.	
7. Jammu & Kashmir	(i)	Shri M.R.S. Bhagat, Secretary, Social Welfare Department, Government of J & K, Srinagar.	
	(ii)	Shri A.R. Zargar Director, Social Welfare Department, Srinagar.	
8. Karnataka	(i)	Shri T.G. Ramakrishnan, Secretary, Department of Social Welfare & Labour, Bangalore.	
	(ii)	Director of Women & Children's Welfare Bangalore.	
9. Kerala	(i)	Shri N. Gopalakrishnan Nair Spl. Secretary, Govt. of Kerala, Local Administration & Social Welfare Department, Trivandrum.	Office : 2477 Res : 6206
	(ii)	Shri V.N. Rayava Panickar, Director, Social Welfare Trivandrum.	Office : 5471 Res : 61164
10. Madhya Pradesh	(i)	Shri Birbal, Secretary, Social Welfare Department, M.P., Bhopal	Office : 61448 Res : 62446
	(ii)	Shri S.D. Sahi, Dy. Secretary, SW Deptt. M.P. Bhopal,	Office : 62416 Res : 2933

(1)	(2)		(3)	(4)
		(iii)	Shri G.S. Shukla, Director, Panchayat & Social Welfare, M.P. Bhopal,	Office : 62016
		(iv)	Smt. Radha Despande, OSD, Spl. Nutrition Programme, S.W. Deptt., Bhopal.	Office : 62033
		(v)	Child Development Project Officer, Singroli Block, Distt. Sidhi, Madhya Pradesh.	
11.	Maharash-tra	(i)	Shri V.B. Mandlekar, Secretary, Social Welfare, Cultural Affairs, Sports and Tourism Department, Government of Maharashtra, Bombay.	
		(ii)	Shri W.M. Shaikh Deputy Secretary Government of Maharashtra, Bombay.	
		(iii)	Dr. (Miss) S. Arora Child Development Project Officer, (Urban Bombay), C/O Director of Health Services, Dental College Bldg., 4th Floor, St. George Hospital Compound, Bombay.	
12.	Manipur		Secretary, Development Department, Government of Manipur, Imphal.	
13.	Megha-laya	(i)	Shri J.M. Phira, Secretary, Social Welfare Department, Government of Meghalaya, Shillong.	
		(ii)	Mrs. M. Syiemlieh, Child Welfare and Probation Officer, Government of Meghalaya, Shillong.	
14.	Naga-land	(i)	Shri T.P. Imchen, Deputy Secretary, Social Welfare Department, Nagaland, Kohima.	Office : 334 Res : 289

<table>
<tr><th>(1)</th><th>(2)</th><th></th><th>(3)</th><th>(4)</th></tr>
<tr><td></td><td></td><td>(ii)</td><td>Shri A.Y. Odyuo, Deputy Director,
Social Welfare Department,
Government of Nagaland, Kohima</td><td>Office : 637
Res : 530</td></tr>
<tr><td>15.</td><td>Orissa</td><td>(i)</td><td>Shri S.K. Basu, Secretary,
Community Dev. & Panchayati
Raj Department,
Government of Orissa, Bhubaneshwar.</td><td>Office : 51450
Res : 51800</td></tr>
<tr><td></td><td></td><td>(ii)</td><td>Shri K.C. Mishra, Director,
Community Development & NES
& GPs and ex-officio—Deputy
Secy., to Govt. of Orissa,
Bhubaneswar.</td><td>Office : 52575
Res : 52562</td></tr>
<tr><td></td><td></td><td>(iii)</td><td>Kumari L.R. Mitra, M.A.,
Under Secretary,
C.D. and Social Welfare Department,
Bhubaneswar.</td><td></td></tr>
<tr><td>16.</td><td>Punjab</td><td>(i)</td><td>Shri P.K. Verma, IAS
Dy. Secretary, Social Welfare
Department, Govt. of Punjab
Chandigarh.</td><td>27634</td></tr>
<tr><td></td><td></td><td>(ii)</td><td>Smt. Joginder Kaur, Spl. Officer
(Slums) Social Welfare, Govt. of
Punjab Chandigarh.</td><td>27984</td></tr>
<tr><td>17.</td><td>Rajasthan</td><td>(i)</td><td>Secretary, Social Welfare Department,
Government of Rajasthan, Jaipur,</td><td></td></tr>
<tr><td></td><td></td><td>(ii)</td><td>Shri Krishan Mohan Sahaya,
Director, Social Welfare,
Government of Rajasthan,
Jaipur.</td><td></td></tr>
<tr><td></td><td></td><td>(iii)</td><td>Director,
Community Development and Panchayat
Department, Government of Rajasthan,
Jaipur.</td><td></td></tr>
</table>

18.	Tamil Nadu	(i)	Smt. S. Satyabhama, IAS Secretary, Social Welfare Deptt. Government of Tamil Nadu Madras.	Per : 2684 Office Ext. 29111/415
		(ii)	Shri P.V. Venkatakrishnan Joint Secy., Social Welfare Department, Govt. of Tamil Nadu Madras.	Per : 25939 Office Ext. 29111/367
		(iii)	Shri S. Arumugham, Assistant Secretary, Department of Social Welfare, Government of Tamil Nadu, Madras.	
		(iv)	Shri R. Vardarajan, Deputy Secretary, Department of Social Welfare, Fort St. George, Madras-9.	
		(v)	Shri S.A. Subraman, I.A.S. Director of Social Welfare, Government of Tamil Nadu, Madras.	443765
19.	Tripura	(i)	Shri K.B. Gurung, Secretary to the Govt. of Tripura, Education Deptt. Agartala	1089
		(ii)	Shri M.K. Chakraborty, Addl. Director, Education Department, Agartala.	535
20.	Uttar Pradesh	(i)	Shri Brij Mohan Pande, Dy. Secretary to the Govt. of U.P., S.W. and Harijan Sahayak Vibhag, Lucknow.	Council House T. No. 603
		(ii)	Smt. Vijai Shilla, Asst. Director, Social Welfare, Lucknow.	26487
		(iii)	Shri Prem Chandra Srivastava, Jt. Secretary, Community Development & Jt. Dev. Commissioner, U.P., Lucknow.	Council House T. No. 654
		(iv)	Dr. P.B. Johri, Jt. Director, Medical and Health Services, Govt. of U.P., Lucknow.	23766

(1)	(2)		(3)	(4)
		(v)	Shri Brahm Swarup Pande, Under Secretary to Govt., Medical Department, Lucknow.	Council House 632
21.	West Bengal	(i)	Shri G.S. Banerji, Secretary, Relief and Welfare Deptt., Government of West Bengal, Calcutta,	
		(ii)	Shri S.N. Ghosh, Dy. Secretary, Relief & Welfare Department, Government of West Bengal, Calcutta.	
		(iii)	Shri M.K. Brahmachari, Director of Social Welfare, Govt. of West Bengal, 45 Ganesh Chandra Avenue, Calcutta.	
		(iv)	Smt. Anu Mukerjee, Asstt. Commissioner for Community Development Department, (Women & Children), Agriculture & Community Development Department, Calcutta.	
22.	Sikkim	(i)	Shri T.S. Gyaltsham, Chief Secretary, Government of Sikkim, Gangtok,	
		(ii)	Col. Y.R. Dani, Director, Health Department, Government of Sikkim, Gangtok.	
23.	Delhi	(i)	Shri R.L. Khanna, Deputy Secretary, Social Welfare, Delhi Administration Delhi.	221058
		(ii)	Shri U. S. Srivastava, Director, Social Welfare, Delhi Administration, Delhi.	
		(iii)	Shri S.K. Gupta, Child Development Project Officer, Social Welfare, Delhi Administration Delhi.	223762

5. Balsevika Training Institute,
Qudsia Garden, Delhi-110006.

6. Balsevika Training Institute,
40 Ramesh Mitra Road, Calcutta.

C. Bhartiya Adimjati Sevak Sangh

(Dr. Ambedkar Marg, Jhandewalan, New Delhi-110055)

1. Santhal Pahadia Sewa Mandal,
Deoghar (Bihar).

2. Tribal Women Training Centre,
Jhalod, Distt. Panchmahal (Gujarat).

3. Adimjati Shiksha Ashram,
Imphal (Manipur)

4. Bhartiya Adimjati Sevak Sangh Training Centre,
Women's Hotel Building, Dimapur (Nagaland).

D. Others

1. Service Home,
Tambaram, Madras (Tamil Nadu).

2. Teachers Training Centre,
Pelliy, Near Gyalzing,
Sikkim.

3. Agriculture Extension Training Centre,
Afim Kothi,
District Pratapgarh, (Uttar Pradesh).

4. Agriculture Extension Training Centre,
Bichpuri, Agra (Uttar Pradesh).

5. Agriculture Extension Training Centre,
District Post Office,
Rae Bareilly. (Uttar Pradesh).